STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375513	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Golden Rule Home	38801 Hardesty Road Shawnee, OK 74801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and facility document review, the facility failed to ensure that the designated director of food service met the minimum required qualifications. Specifically, the facility did not employ a full-time Registered Dietitian (RD), and the facility Dietary Manager (DM) was not a certified dietary manager or certified food service manager, nor did she have an associate's degree or higher in food service management. This failed practice had the potential to affect 52 residents who received meals from the kitchen (total census: 56).Findings included: A facility Job Description & [and] Orientation Checklist, dated 07/1998, indicated the Dietary Manager (DM) position required, Bachelor's degree (B.A.) from four-year college or university; or one to two years related experience and/or training; or equivalent combination of education and experience. The job description further indicated the DM, Must hold or be capable of acquiring certificates required by the state. In an interview on 06/08/2026 at 10:14 AM, the DM stated she was not a Certified Dietary Manager (CDM) but was currently enrolled in the course. The DM stated the facility Registered Dietitian was at the facility one day per month. In an interview on 06/11/2026 at 1:13 PM, the DM stated she had been in the Dietary Manager position for about a year. The DM stated she had completed the Food Service Manager Exam and had a certificate. In an interview on 06/11/2026 at 2:04 PM, the Executive Director (ED) stated she thought the DM had a Food Service Manager certificate. In an interview on 06/11/2026 at 2:07 PM, the DM stated she did not have a Food Service Manager certificate. The DM stated she previously had the certification, but it had expired and she did not have a copy of the expired certificate. The DM stated she was working with the Registered Dietitian to do the Food Service Manager program and Certified Dietary Manager program. A review of the DM's employee file revealed the DM did not have an associate degree or bachelor's degree. The DM's employee file did not include any documentation that the DM was a Certified Dietary Manager or Certified Food Service Manager. In a telephone interview on 06/11/2026 at 3:42 PM, the Registered Dietitian stated the DM had a food handler certificate that all the kitchen staff completed once per year. The RD stated she thought the DM had a Food Service Manager certification, but because the RD was a contracted employee, she did not keep any employee records. The RD stated she would expect the DM to have the Food Service Manager certification after being in the position for a year. In an interview on 06/12/2026 at 8:40 AM, the ED stated she usually managed the hiring process. The ED stated the facility did not have a completed job description and orientation checklist for the DM. In an interview on 06/12/2026 at 12:50 PM, the ADM stated he was not aware that the DM did not have food service manager certificate. In a follow-up interview on 06/12/2026 at 3:26 PM, the DM confirmed that she did not have her Certified Dietary Manager or Certified Food Service Manager certifications. The DM further confirmed that she did not have an associate's or higher degree in food service management or hospitality. The DM stated she had been in the management position for about a year, with no previous experience as a food service director at any other nursing facility.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and facility document and policy review, the facility failed to follow the planned, written menu for 1 of 2 meals observed. Specifically, the facility served incorrect portion sizes for the lunch meal on 06/09/2026. This failure had the potential to affect 52 residents who received meals from the kitchen (total census: 56).Findings included: A facility policy titled Menus, revised 10/2008, indicated Menus shall a) meet the nutritional needs of residents; b) be prepared in advance; and c) be followed. A facility Menu Guide Report for the lunch meal on Tuesday 06/09/2026 indicated the planned menu included 1/3 cup (c.) garlic mashed potatoes and 1/3 c. green peas for regular diets, pureed diets, and mechanical soft diets. The menu also included a #12 (1/3 c.) dipper of pureed meatloaf and a #16 (1/4 c.) dipper of pureed bread for residents on pureed diets. During observations of the lunch meal on 06/09/2026 beginning at 12:05 PM, the Dietary Manager (DM) served the mashed potatoes for all diets and the pureed meat and pureed green peas for pureed diets with a blue #16 (1/4 c.) dipper. The DM served the pureed bread with a black #30 (1/8 c.) dipper. In an interview on 06/09/2026 at 12:22 PM, the DM confirmed she had used a #16 dipper to serve mashed potatoes, pureed meat, and pureed green peas. The DM confirmed that she had used the #30 dipper to serve the pureed bread. The DM stated dietary staff should look in the menu book to know what size portion to serve. The DM looked at the menu and confirmed that she should have used the #12 (1/3 c.) dipper. The DM stated they had always used the blue #16 dippers and did not have enough of the #12 dippers to serve that size portion. The DM stated if they served the wrong portion sizes, residents could receive too much or too little food. In a telephone interview on 06/11/2026 at 3:42 PM, the Registered Dietitian (RD) stated she reviewed and approved the menus. The RD stated she expected the kitchen staff to follow the menus or make appropriate substitutions. The RD stated she expected staff to serve the correct portion sizes to ensure that residents received the right amount of nutrients. In an interview on 06/12/2026 at 11:58 AM, the Director of Nursing (DON) stated she expected the kitchen staff to follow the menus to meet the regulations. In an interview on 06/12/2026 at 12:50 PM, the Administrator (ADM) stated he expected the kitchen to follow the policy and procedures for following the menus. The ADM stated he was not aware that the kitchen did not have enough of the proper-sized dippers.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and facility document and policy review, the facility failed to ensure the Medical Director participated in the facility's Quality Assurance and Performance Improvement (QAPI) Committee meetings as required for 13 of 13 reviewed QAPI meetings held during the timeframe from 05/30/2025 through 05/29/2026.Findings included: A facility policy titled. Quality Assurance and Performance Improvement (QAPI) Committee, dated 04/2014, revealed, This facility shall establish and maintain a Quality Assurance and Performance Improvement (QAPI) Committee that oversees the implementation of the QAPI Program. The policy specified, 3. The following individuals will serve on the committee: d. Medical Director. Review of QAPI meeting sign-in sheet dated 05/30/2025, 06/30/2025, 07/31/2025, 08/29/2025, 09/30/2025, 10/31/2025, 11/28/2025, 12/29/2025, 01/30/2026, 02/27/2026, 03/31/2026, 04/29/2026, and 05/29/2026 revealed no documented evidence the Medical Director participated in the meetings.During an interview on 06/12/2026 at 1:27 PM, the Administrator reviewed the QAPI meeting sign-in sheets and confirmed the signatures of those who signed as having attended and stated the Medical Director had not attended. During an interview on 06/12/2026 at 1:40 PM, the Administrator stated the Medical Director was in the facility on Wednesdays, but QAPI meetings did not always fall on Wednesdays. He stated the Medical Director's availability was limited. The Administrator stated they could reach out to the Medical Director if there were concerns but stated the Medical Director did not participate in the QAPI meetings by phone either. The Administrator suggested the facility may need to start conducting QAPI meetings at times the Medical Director was in the facility.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on record review, interview, and facility policy review, the facility failed to ensure Minimum Data Set (MDS) assessments were completed on a quarterly basis and submitted within the required timeframe for 17 (Residents #33, #12, #16, #17, #18, #22, #23, #3, #35, #38, #40, #43, #44, #45, #5, #54, and #8) of 18 residents reviewed for resident assessments. Findings included: A facility policy titled, Resident Assessment Instrument, revised 09/2010, specified, 1. The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following schedule: c. at least quarterly. The State Operations Manual Appendix PP guidance at F638 indicated, A Quarterly assessment is considered timely if:- The Assessment Reference Date (ARD) of the Quarterly MDS is within 92 days (ARD of most recent OBRA [Omnibus Budget Reconciliation Act] assessment + [plus] 92 days) after the ARD of the previous OBRA assessment (Quarterly, Admission, Annual, Significant Change in Status, Significant Correction to Prior Comprehensive or Quarterly assessment) AND- The MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (ARD +14 days).If the resident has experienced a significant change in status, the next quarterly review is due no later than 3 months after the ARD of the Significant Change in Status Assessment. During an interview on 06/10/2026 at 8:40 AM, the Director of Nursing (DON) explained the symbols displayed within the MDS screen of the facility's electronic medical records (EMR) system. The DON stated a thumbs up symbol in the EMR system meant the assessment was accepted by CMS. A triangle symbol (with an exclamation mark) meant the assessments were submitted late. She stated she kept a calendar to keep up with the dates when the MDS assessments were due. 1. An admission Summary revealed the facility admitted Resident #33 on 11/14/2025. According to the admission Summary, the resident had a medical history that included diagnoses of essential hypertension and polyneuropathy. A quarterly MDS with an ARD of 02/17/2026 revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. As of 06/10/2026, the quarterly MDS with an ARD of 02/17/2026 was the most recently completed MDS assessment available for review for Resident #33. 2. An admission Summary revealed the facility admitted Resident #12 on 05/30/2025. According to the admission Summary, the resident had a medical history that included diagnoses of essential hypertension and type 2 diabetes mellitus. Resident #12's MDS records revealed that the most recent quarterly MDS had an ARD of 12/14/2025. A significant change MDS with an ARD of 12/25/2025 revealed Resident #12 had a BIMS score of 13, which indicated the resident had intact cognition. As of 06/10/2026, the 12/25/2025 significant change MDS was the most recent MDS assessment available for review for Resident #12. 3. An admission Summary revealed the facility admitted Resident #16 on 01/02/2026. According to the admission Summary, the resident had a medical history that included diagnoses of depression and anxiety disorder. Resident #16's electronic medical record (EMR) revealed a quarterly MDS with a created date of 05/15/2026. As of 06/10/2026, the EMR screen had a triangle symbol with an exclamation mark next to the 05/15/2026 MDS entry, indicating the assessment was submitted late. There was no thumbs up symbol to indicate the assessment had been accepted by CMS. The EMR also revealed a discharge MDS with a created date of 05/15/2026. The discharge assessment had no thumbs-up symbol to indicate the assessment had been accepted by CMS, and there was a triangle/exclamation mark symbol to indicate late submission. The most recent MDS documented as having been completed and accepted was an admission MDS with an ARD of 01/06/2026. 4. An admission Summary revealed the facility admitted Resident #17 on 01/19/2026. According to the admission Summary, the resident had a medical history that included diagnoses of hyperlipidemia and depressive disorder. Resident #17's EMR revealed a quarterly MDS with a created date of 05/15/2026 that had not been completed and submitted as of 06/10/2026. There was a triangle/exclamation mark symbol and no thumbs up symbol next to the assessment. The most recent MDS assessment that was documented as having been completed and accepted was an admission (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS with an ARD of 01/26/2026. 5. An admission Summary revealed the facility admitted Resident #18 on 11/06/2023. According to the admission Summary, the resident had a medical history that included diagnoses of depression and anxiety disorder. A quarterly MDS with an ARD of 05/03/2026 revealed Resident #18 had a BIMS score of 15, which indicated the resident had intact cognition. Resident #18's EMR revealed the quarterly MDS with an ARD of 05/03/2026 (which had a created date of 05/28/2026) had not been completed and submitted as of 06/10/2026. There was a triangle/exclamation mark symbol and no thumbs up symbol next to the assessment. The most recent MDS that was documented as having been completed and accepted was a quarterly MDS with an ARD of 01/31/2026. 6. An admission Summary revealed the facility admitted Resident #22 on 06/05/2025. According to the admission Summary, the resident had a medical history that included diagnoses of hypertension and muscle spasms. Resident #22's EMR revealed a quarterly MDS with a created date of 05/15/2026 that had not been completed and submitted as of 06/10/2026. The EMR also revealed a discharge MDS with a created date of 06/03/2026 that had not been completed and submitted. There were triangle/exclamation mark symbols and no thumbs up symbols next to the two assessments. The most recent MDS that was documented as having been completed and accepted was a quarterly MDS with an ARD of 01/03/2026. 7. An admission Summary revealed the facility admitted Resident #23 on 01/31/2026. According to the admission Summary, the resident had a medical history that included diagnoses of pain and osteoporosis. Resident #23's EMR revealed a quarterly MDS with a created date of 05/15/2026 and an ARD date of 05/05/2026 that had not been completed and submitted as of 06/10/2026. There was a triangle/exclamation mark symbol and no thumbs up symbol next to the assessment. The most recent MDS documented as having been completed was a quarterly MDS with an ARD of 01/03/2026, which indicated the next quarterly MDS would have been due by 04/03/2026. 8. An admission Summary revealed the facility admitted Resident #3 on 03/14/2019. According to the admission Summary, the resident had a medical history that included diagnoses of type 2 diabetes mellitus and gastro esophageal reflux. Resident #3's EMR revealed a quarterly MDS with a created date of 05/15/2026 that had not been completed and submitted as of 06/10/2026. There was a triangle/exclamation mark symbol and no thumbs up symbol next to the assessment. The previous quarterly MDS had an ARD of 01/16/2026, which indicated the next MDS would have been due by 04/16/2026. 9. An admission Summary revealed the facility admitted Resident #35 on 07/20/2021. According to the admission Summary, the resident had a medical history that included diagnoses of severe intellectual disability and cerebral palsy. Resident #35's EMR revealed a quarterly MDS with a created date of 05/15/2026 that had not been completed and submitted as of 06/10/2026. There was a triangle/exclamation mark symbol and no thumbs up symbol next to the assessment. The previous quarterly MDS had an ARD of 12/26/2025, which indicated the next MDS would have been due by 03/26/2026. 10. An admission Summary revealed the facility admitted Resident #38 on 10/03/2024. According to the admission Summary, the resident had a medical history that included diagnoses of type 2 diabetes and hypertension. Resident #38's EMR revealed a quarterly MDS with a created date of 05/15/2026 that had not been completed and submitted as of 06/10/2026. There was a triangle/exclamation mark symbol and no thumbs up symbol next to the assessment. The previous quarterly MDS had an ARD of 01/03/2026, which indicated the next MDS would have been due by 04/03/2026. 11. An admission Summary revealed the facility admitted Resident #40 on 12/03/2022. According to the admission Summary, the resident had a medical history that included diagnoses of gastro esophageal reflux and hypothyroidism. Resident #40's EMR revealed a quarterly MDS with a created date of 05/15/2026 that had not been completed and submitted as of 06/10/2026. There was a triangle/exclamation mark symbol and no thumbs up symbol next to the assessment. The previous quarterly MDS had an ARD of 01/29/2026, which indicated the next MDS would have been due by 04/29/2026. 12. An admission Summary revealed the facility admitted Resident #43 on 12/03/2022. According to the admission Summary, the resident had a medical history that included diagnoses of gastro esophageal reflux and hypothyroidism. Resident (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#43's EMR revealed a quarterly MDS with a created date of 05/15/2026 that had not been completed and submitted by 06/10/2026. There was a triangle/exclamation mark symbol and no thumbs up symbol next to the assessment. The most recent MDS documented as having been completed and accepted was an admission assessment with an ARD of 01/28/2026. 13. An admission Summary revealed the facility admitted Resident #44 on 01/09/2026. According to the admission Summary, the resident had a medical history that included diagnoses of pain and major depressive disorder. Resident #44's EMR revealed a quarterly MDS with a created date of 05/15/2026 that had not been completed and submitted as of 06/10/2026. There was a triangle/exclamation mark symbol and no thumbs up symbol next to the assessment. The most recent MDS documented as having been completed and accepted was an admission assessment with an ARD of 01/19/2026. 14. An admission Summary revealed the facility admitted Resident #45 on 01/09/2026. According to the admission Summary, the resident had a medical history that included diagnoses of gastro esophageal reflux and insomnia. Resident #45's EMR revealed a quarterly MDS with a created date of 05/15/2026 that had not been completed and submitted as of 06/10/2026. There was a triangle/exclamation mark symbol and no thumbs up symbol next to the assessment. The previous quarterly MDS had an ARD of 01/29/2026, which indicated the next MDS would have been due by 04/29/2026. 15. An admission Summary revealed the facility admitted Resident #5 on 01/09/2026. According to the admission Summary, the resident had a medical history that included diagnoses of hypertension and kidney failure. Resident #5's EMR revealed a quarterly MDS with a created date of 05/15/2026 that had not been completed and submitted as of 06/10/2026. There was a triangle/exclamation mark symbol and no thumbs up symbol next to the assessment. The most recent MDS documented as having been completed as an admission assessment with an ARD of 01/17/2026. 16. An admission Summary revealed the facility admitted Resident #54 on 09/25/2025. According to the admission Summary, the resident had a medical history that included diagnoses of end stage renal disease and hypertension. Resident #54's EMR revealed a quarterly MDS with a created date of 05/15/2026 and an ARD of 03/25/2026 that had not been completed and submitted as of 06/10/2026. There was a triangle/exclamation mark symbol and no thumbs up symbol next to the assessment. 17. An admission Summary revealed the facility admitted Resident #8 on 11/20/2024. According to the admission Summary, the resident had a medical history that included diagnoses of osteoporosis and heart failure. Resident #8's EMR revealed a quarterly MDS with a created date of 05/15/2026 and an ARD of 05/01/2026 that had not been completed and submitted as of 06/10/2026. There was a triangle/exclamation mark symbol and no thumbs up symbol next to the assessment. The previous quarterly MDS had an ARD of 01/31/2026, which indicated the next MDS would have been due by 05/01/2026. During an interview on 06/12/2026 at 10:13 AM, the DON stated she was in charge of completing the MDS assessments. She stated there were late MDS assessments pending when she started her employment with the facility three weeks ago. She stated no one was completing the MDS assessments after the former DON was no longer working at the facility. The DON stated she went through each resident's record individually to catch up the MDS assessments, starting with the month of February 2026. She stated the MDS assessment should be submitted quarterly and with any significant change. After that, she had 14 days to submit the MDS assessments to CMS. The DON provided the following information about the individual residents' assessments: - The DON stated Resident #12 was not in the facility's EMR system to enable her to complete the MDS because the resident had been discharged and their record was archived. She stated no discharge MDS was completed for Resident #12. - The DON confirmed the quarterly MDS assessments for Residents #33, #12, #16, #17, #18, #22, #23, #3, #35, #38, #40, #43, #44, #45, #5, #54, and #8 were not completed and submitted timely. During an interview on 06/12/2026 at 1:40 PM, the Administrator stated the facility had a lapse in completing the MDS assessments because the person completing the MDS assessments left. His expectation was for staff to follow the policy and procedure.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to assess smoking safety prior to allowing residents to smoke unsupervised, failed to supervise residents who required supervision with smoking, and failed to ensure residents who smoked did so in accordance with the facility's smoking policy. Failed practices were identified for 3 (Residents #68, #50, and #55) of 3 residents reviewed for smoking. The failed practices had the potential to affect 14 residents who smoked, according to a list provided by the facility. Specifically, the facility failed to:- reassess smoking safety and need for supervision for Resident #68 after the resident was observed in the smoking area with oxygen in use on two occasions;- assess Resident #50 for safety while smoking; and,- provide supervision with smoking to Resident #55, whose assessment indicated they were an unsafe smoker.Findings included: An undated facility policy titled, The Golden Rule Smoking/Vaping Policy indicated, All residents who smoke/vape will have a Safe Smoking Assessment completed upon or prior to admission and then will be re-evaluated periodically and/or upon a change in condition. The policy indicated, For the safety of our residents and staff, ALL residents that smoke, are not permitted to smoke with oxygen on or with oxygen cylinders in the smoking area. The policy further indicated, Residents that have been determined to be 'unsafe smokers,' may smoke in the designated area, but ONLY with supervision and only at designated smoke times. Unsafe smokers cannot keep any smoking material in their rooms or on their person. 1. An admission Summary (Standard) indicated the facility admitted Resident #68 on 01/09/2026. According to the admission Summary, the resident had a medical history that included diagnoses of polyneuropathy, dependence on supplemental oxygen, obstructive pulmonary disease, and type 2 diabetes mellitus. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/28/2026, revealed Resident #68 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident had no limitations in functional range of motion of the upper extremities. According to the MDS, the resident had shortness of breath, currently used tobacco, and received oxygen therapy. Resident #68's Care Plan, with an onset date of 01/23/2026, included a Category/Problem statement that revealed the resident was homeless as a result of a fire, having lost all of their belongings. The Category/Problem statement indicted Resident #68 had not planned to move to a nursing home and was acclimating to the environment. The Category/Approaches section of the care plan revealed Resident #68 liked to go outside to the patio to smoke. Another Category/Problem statement indicated Resident #68 became teary when they had an altercation with a previous roommate and required redirection and distraction. The Category/Approaches section directed staff to remind the resident of the dangers of not following the physician's advice such as smoking, safe smoking practices, and following the physician's orders. The Care Plan also indicated the resident had been educated on the dangers of smoking and offered tools to help them quit smoking, but Resident #68 chose to continue to smoke. The Care Plan directed staff to redirect the resident when their behaviors were inappropriate and to remind the resident that oxygen must be removed prior to smoking for fire safety. Resident #68's Safe Smoking Assessment dated 01/09/2026 included Yes responses to all questions, meaning the resident had no cognitive, visual, communication, or physical concerns that would prevent them from smoking safely. The Registered Nurse (RN) who signed as having completed the Yes/No questions section of the form did not check a response at the bottom of the form to indicate whether Resident #68 was deemed to be a Safe smoker or an Unsafe smoker. The bottom section of the form contained a space for an interdisciplinary team (IDT) member to sign and date the form. The signature and date line were left blank. Resident #68's Nurses Notes, dated 04/20/2026 at 10:00 AM and authored by Licensed Practical Nurse (LPN) #3, indicated the resident had increased lethargy and was unable to hold a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication cup, spilling the contents on the floor. The note indicated that the resident was slurring words and unable to keep their eyes open. A Nurse's Note, dated 04/20/2026 at 12:00 PM and authored by LPN #3, indicated that Resident #68 was outside in the smoking area with their oxygen on. The note indicated that the resident was removed from the smoking area and education provided. The note indicated that the resident denied smoking, and the nurse revealed that it was explained to the resident that the resident had been witnessed smoking. The resident then denied that the oxygen was turned on, and the note indicated that the resident was shown that the oxygen was on. The note indicated that Resident #68 was educated on not taking their oxygen outside to the smoking area. A Nurse's Note, dated 04/21/2026 at 11:00 AM and authored by LPN #3, revealed that Resident #68 was outside in the smoking area with their oxygen on. The note indicated that the Social Services Director (SSD) was notified the resident was noncompliant with removing their oxygen when outside smoking. A Notes Report for the timeframe from 01/01/2000 through 06/30/2026 revealed that on 04/21/2026 at 11:37 AM, the SSD documented in the notes that she was informed that Resident #68 had been outside around smokers with their oxygen on. The note indicated that the SSD went outside and had a conversation with the resident and informed the resident that no resident was to be in the smoking area while using oxygen. Further review of smoking information for Resident #68 revealed a copy of the facility's Smoking/Vaping Policy was signed by Resident #68 on 05/13/2026. Resident #68 was interviewed on 06/10/2026 at 8:50 AM and stated that when staff observed them in the smoking area with oxygen, the oxygen was not turned on, and the tubing was not connected to the oxygen machine. Resident #68 stated they went to the smoking area every two to three hours, adding that sometimes they just sat outside and sometimes they smoked. Resident #68 stated they kept their own smoking materials and had no supervision when smoking. The resident remembered being approached by the Executive Director (ED) and the SSD about smoking but was unable to recall Licensed Practical Nurse (LPN) #3 addressing the smoking and oxygen issue with them. Resident #68 confirmed again that the oxygen tank was not turned on and they had not been smoking at the time they were approached by staff. Certified Nursing Assistant (CNA) #9 was interviewed on 06/10/2026 at 9:05 AM and stated she had not observed any residents using oxygen in the smoking area. The CNA stated most residents were independent smokers and were allowed to keep their smoking materials. CNA #6 was interviewed on 06/10/2026 at 9:10 AM and stated she had not seen any residents smoking while using oxygen, and if she did, she would report it to the nurse and remind the resident they should not be wearing oxygen while smoking. During an interview on 06/10/2026 at 9:15 AM, LPN #3, who authored the 04/20/2026 and 04/21/2026 nurse's notes regarding Resident #68's smoking, stated Resident #68 used a portable oxygen tank and had been sitting in the smoking area with the oxygen tank. LPN #3 stated he had reminded the resident to leave the oxygen in the facility, and the resident agreed. LPN #3 stated that after he saw Resident #68 on 04/20/2026 in the smoking area with the oxygen, he saw the resident again in the smoking area with the oxygen tank and got the ED to go with him and witness the resident with the oxygen tank in the smoking area. LPN #3 stated there were no problems after that day. LPN #3 then reviewed the 04/20/2026 note that indicated he had seen Resident #68 smoking and stated he had not actually seen the resident smoking but had seen the resident sitting with a cigarette in one hand and the lighter in the other hand, adding he knew if he had not gone outside and stopped the resident, Resident #68 would have lit the cigarette. LPN #3 stated that at the time he stopped the resident, the resident's oxygen was functioning, and the resident was receiving oxygen through the nasal cannula. LPN #3 stated he turned the oxygen off and took the oxygen tank into the facility and acknowledged he had not documented any of his actions. LPN #3 stated he and the ED educated Resident #68 but had not documented what the education was about. The LPN stated Resident #68's smoking materials were not removed from the resident; he could give no reason why the smoking materials were not taken from the resident and stated he had not reassessed the resident for safe smoking. LPN #3 reviewed the nurse's notes he had written on 04/21/2026 and stated he had gotten the SSD to go with him to the smoking area to speak with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #68 about the resident's non-compliance with the smoking policy. The LPN stated the SSD told Resident #68 that if they wanted to go outside to just sit, to choose another location rather than going to the smoking area. LPN #3 stated he had not documented that education. LPN #3 stated he was unable to remember if there were any other residents in the smoking area when Resident #68 was there with their oxygen on 04/20/2026 or on 04/21/2026. LPN #3 stated smoking assessments were completed on admission by the admitting nurse. LPN #3 stated if Resident #68 had continued to smoke while using oxygen, the resident could have caught on fire or an explosion could have occurred that affected the entire facility. The Director of Nursing (DON) was interviewed on 06/10/2026 at 9:42 AM. The DON stated that smoking assessments were completed on admission and upon a change in condition and were completed by the assistant DON (ADON) or the charge nurse. The DON described unsafe smoking practices, such as a resident being unable to hold the cigarette, falling asleep while smoking, cognitive impairment, or smoking with oxygen on, but stated that each resident and situation was different. The DON stated if a resident with oxygen was alert and oriented, additional education and monitoring may be sufficient and defined monitoring as having the resident come by the nurse's station before going out to make sure the oxygen was not with the resident. The DON stated she had worked at the facility for three weeks, and she had no knowledge of any resident smoking with oxygen in use, but she had been made aware of a resident that had been in the smoking area with oxygen. The DON stated she had been informed that the resident had been educated and now left the oxygen inside the facility. The DON stated that upon admission, residents were asked if they smoked, and if they did smoke, a smoking assessment was completed. The DON stated she expected the resident's smoking status to be care planned, with smoking as the focus area and appropriate goals and interventions. The DON stated if a resident was smoking or in the smoking area with oxygen, the care plan should be revised to identify the hazard. The DON stated if a resident was observed smoking with oxygen, she expected a safe smoking reassessment to be completed. An observation was made on 06/10/2026 at 11:02 AM of Resident #68 returning to the facility from the smoking area. There was no oxygen tank on the resident's wheelchair. On 06/10/2026 at 11:09 AM, the ED was interviewed and stated she had educated Resident #68 that the resident was unable to go to the smoking area with oxygen in use. After that, the resident left the oxygen canister inside the facility. The ED stated Resident #68 also went outside to sit, since the resident frequently had no cigarettes. The ED stated she had not documented the education given to Resident #68. The ED stated the resident was frequently non-compliant with all things, but she had observed the oxygen being left by the door. However, since she was not there all the time, she could not say that the resident had not gone out with the oxygen again. The ED stated she was not sure what the smoking assessment said, and even if they did another smoking assessment, the resident was still going to be non-compliant with the smoking policy. The ED stated the way to make sure that all residents were safe was to keep an eye on Resident #68. The ED stated they had never given Resident #68 smoking materials and stated if she asked Resident #68 if they had smoking materials, the resident would say no. The ED stated she was not able to strip search the resident looking for smoking materials. The ED stated she expected Resident #68's care plan to reflect the resident's non-compliance with the smoking policy. Resident #64, who was identified as one of the 14 residents in the facility who smoked, was interviewed on 06/10/2026 at 11:23 AM. Resident #64 stated they admitted to the facility on [DATE] and had not seen any residents in the smoking area with an oxygen tank. Resident #64 stated the resident who used oxygen took the oxygen tank off their wheelchair and left it inside the facility when they went out to smoke. Resident #64's admission MDS, with an ARD of 05/27/2026, indicated the resident scored 15 on a BIMS, which indicated the resident had intact cognition. Resident #68 was interviewed again on 06/10/2026 at 1:50 PM and stated they used a small oxygen machine that fit on the side of the wheelchair. Resident #68 stated the machine was not heavy and was very manageable and that they were able to easily take the machine off the wheelchair and leave it in facility before going out to smoke. Resident #68 stated they had not used the portable oxygen machine in the past (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #55's cigarettes in the medication room but gave Resident #55 a pack at a time to keep on their person. In an interview on 06/12/2026 at 12:42 PM, the Director of Nursing (DON) stated residents who smoked should have complete and accurate assessments. The DON stated if the assessment indicated a resident should be supervised, then she would expect them to be supervised. In an interview on 06/12/2026 at 12:50 PM, the Administrator (ADM) stated he expected residents who smoked to have a smoking assessment. The ADM stated the facility needed to find a way to keep the assessments updated. The ADM stated if the assessment indicated a resident was unsafe, staff should determine what was needed and implement appropriate interventions to assist them.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident was assessed for the ability to safely self-administer medication and failed to obtain a physician's order prior to allowing the resident to self-administer medication for 1 (Resident #33) of 8 sampled residents reviewed for self-administration of medications.Findings included: A facility policy titled, Administering Medications, revised 04/2010, specified, 18. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do safely. A facility policy titled, Self-Administration of Medications, revised 12/2012, specified, Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. Policy Interpretation and Implementation 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications. An admission Summary revealed the facility admitted Resident #33 on 11/14/2025. According to the admission Summary, the resident had a medical history that included diagnoses of essential hypertension and polyneuropathy. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) 02/17/2026, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had shortness of breath or trouble breathing with exertion. Resident #33's June 2026 Physician's Orders contained an order, dated 11/14/2025, for ipratropium bromide 0.02 percent (%), one vial inhale by mouth via nebulizer three times a day as needed. There was no order to self-administer any medications, specifically nebulizer treatments or to keep medications at bedside. Resident #33's Care Plan, dated 11/21/2025, included a category problem that indicated the resident was at risk for shortness of breath. Interventions directed staff to administer medications as ordered and administer ipratropium as ordered by the physician. There was no evidence of a category or approach that indicated the resident could self-administer their medications. During a concurrent observation and interview on 06/08/2026 at 11:27 AM, Resident #33 was seated in a wheelchair in their room with a nebulizer machine in the room. Resident #33 stated they normally self-administered their nebulizer treatment as needed. During a concurrent observation and interview on 06/08/2026 at 11:44 AM, Resident #33 was observed seated in a wheelchair in their room and self-administering a nebulizer treatment. Resident #33 had the nebulizer mouthpiece up to their mouth with the nebulizer machine on and solution in the medication cup of the nebulizer machine. Resident #33 stated they were administering a nebulizer treatment. They stated they kept the nebulizing medication in their room. Resident #33 stated they wanted to self-administer the nebulizing treatment but did not know if they had been assessed to self-administer. During a concurrent observation and interview on 06/08/2026 at 11:46 AM, as Resident #33 had the nebulizer on and mouthpiece in their mouth, they opened a bedside drawer and showed four vials of ipratropium bromide inhalation solution. Resident #33 stated Licensed Practical Nurse (LPN) #3 gave them the nebulizing solution to self-administer as needed. During an interview on 06/09/2026 at 1:28 PM, LPN #2 confirmed Resident #33 had a PRN order for ipratropium. She stated that Resident #33 did not have a physician's order and had not been assessed to self-administer medications. She stated before a resident could self-administer medications, they should have an assessment to self-administer and a physician's order. She stated she expected only residents who had been assessed with a physician's order to self-administer medications. She stated that otherwise a resident should not be self-administering medications without a physician's order and should not keep medications in their room. During an interview on 06/09/2026 at 1:33 PM, LPN #3 confirmed Resident #33 had a PRN order for ipratropium and stated he was responsible for Resident #33's care on 06/08/2026 and 06/09/2026. He stated he thought Resident #33 had been assessed to self-administer ipratropium nebulizing treatments. He stated that when Resident #33 asked for a nebulizing treatment, he gave them one vial of the ipratropium, but it (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had been weeks ago because they had not asked for it since then. During an interview on 06/09/2026 at 1:37 PM, LPN #3 stated that when a resident had not been assessed to self-administer medications they should not be doing so. He stated he gave the medication to Resident #33 to self-administer because he thought they had been assessed and had a physician's order to self-administer. He stated Resident #33 should not have had the vials of ipratropium in their room. During an interview on 06/09/2026 at 2:26 PM, LPN #3 stated the process for self-administration would be to look at the resident's physician's orders, care plan, and assessment before allowing a resident to self-administer, but he did not do that before giving the resident the ipratropium and allowing the resident to self-administer. He stated that the Previous Director of Nursing (DON) told him the resident could self-administer medications. During an interview on 06/10/2026 at 10:07 AM, the Nurse Practitioner (NP) stated that when a resident had not been assessed as competent to self-administer medications, they should not be self-administering medication. He further stated that when there was no physician's order or assessment to self-administer medications, then medications should not be left at a resident's bedside. During an interview on 06/11/2026 at 1:49 PM, the Pharmacist stated residents should not self-administer medications or have medications at their bedside if they did not have an assessment or physician's order to self-administer. During an interview 06/11/2026 at 2:02 PM, the Previous DON stated she did not remember if Resident #33 had a self-administration assessment or physician's order to self-administer, but if they did, it would be in their medical record. She stated that before a resident self-administered, they must have a physician's order and assessment. She stated she did not tell any staff that Resident #33 could self-administer ipratropium nebulizing solution. During an interview on 06/11/2026 at 2:46 PM, the DON stated that before a resident self-administered medication they must be assessed first, the doctor must approve that a resident could safely self-administer, and then a physician's order must be obtained to self-administer. She stated that some medications could be stored safely in a resident's room in a locked box if they had been assessed to self-administer medications, but respiratory medications were not generally stored in a resident's room because they must be assessed prior to and after the respiratory treatment. She stated a nurse should not have given Resident #33 any nebulizing treatment to self-administer because they did not have a physician's order or an assessment to self-administer. She stated that when LPN #3 knew Resident #33 wanted to self-administer the nebulizing treatment he should have gotten the resident assessed and consulted with the physician before giving the resident medication to self-administer. She stated she expected residents to self-administer medication only if they had been deemed clinically appropriate and had a physician's order to do so. During an interview on 06/11/2026 at 3:23 PM, the Administrator stated he would defer to nursing on the self-administration process and procedure.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, record review, and facility document and policy review, the facility failed to ensure a certified nursing assistant (CNA) immediately reported an allegation of suspected abuse in a manner consistent with the process outlined in the facility's abuse policy for an incident involving 1 (Resident #20) of 4 sampled residents reviewed for abuse. Specifically, CNA #11 notified the off-duty Assistant Director of Nursing (ADON) of suspected abuse by way of text message instead of notifying a supervisor on-duty or the facility's Abuse Coordinator directly as specified in the facility's abuse policy, which resulted in a delayed initial report submission to the state survey agency (SSA).Findings included: An undated facility policy titled, Abuse and Neglect Prohibition Program, Section 3, revealed, When abuse, neglect, mistreatment, or misappropriation of personal property of a resident is observed, or suspected, staff must immediately notify their supervisor on duty, who, in turn, should notify the abuse coordinator/administrator and director of nursing services. The policy further revealed, Reporting & [and] Investigating: We follow a specific procedure to report and investigate allegations. This ensures that the resident receives appropriate care, that an investigation is begun, and that the resident's care plan is adjusted, as needed. An admission Summary (Standard) revealed the facility admitted Resident #20 on 07/01/2025. According to the admission Summary, Resident #20 had a medical history that included diagnoses of Alzheimer's disease, anxiety disorder, and major depressive disorder. Resident #20's Nurse's Notes revealed an untimed entry dated 05/18/2026 that indicated after dinner a nurse was seated at the nurse's station. According to the note, the nurse turned and observed a CNA sitting at eye-level and talking with Resident #20. The note indicated that Resident #20 slapped the CNA on the left side of the face, and the CNA quickly got up from the chair c [with] his hands raised like trying to block another slap. According to the note, the nurse requested the CNA step away while the nurse took over sitting with and monitoring the resident. The note indicated that while the nurse tried to assess the resident, the resident took items off the desk and the medication cart and upon assessment, the nurse identified two small skin tears on the back of Resident #20's left hand that were actively bleeding. A copy of text message correspondence from CNA #11 to the ADON, dated Yesterday [05/18/2026] 5:54 PM, revealed CNA #11 initially contacted the ADON to report that something happened that bothered her and she did not know who else to talk to about it. Per the text message correspondence, the ADON responded at an unknown time and asked what happened. CNA #11 responded at an unknown time and described that CNA #10 got close to a resident's face and when the resident attempted to hit CNA #10, CNA #10 grabbed [the resident's] arms really tight and yelled at [the resident] not to hit. Per the text message, after CNA #10 let go of the resident's arms, the resident slapped CNA #10.A facsimile Confirmation Report revealed the facility submitted an initial report involving Resident #20 to the SSA on 05/19/2026 at 1:29 PM. An undated initial Incident Report Form revealed the facility submitted an allegation of abuse/mistreatment involving Resident #20 and CNA #10. The initial Report Form indicated that it was reported that on 05/18/2026 at the nurse's station, CNA #10 allegedly maintained proximity to Resident #20's face and guided the resident's left hand and placed it on the resident's lap while redirecting the resident from sliding out of their wheelchair. A telephone interview was held with CNA #11 on 06/12/2026 at 11:50 AM. CNA #11 stated she did not recall what happened during the alleged incident but she notified the ADON of the events; however, CNA #11 stated she deleted the messages after she sent them and then just left it alone. The ADON was interviewed on 06/11/2026 at 2:51 PM and stated she was not in the building when the alleged incident occurred. The ADON stated CNA #11 sent her a text message about an incident at the facility that made the CNA feel uncomfortable, but the message did not say who or what was involved. The ADON initially stated she did not reply to the message; however, after reviewing a copy of the text message correspondence, she stated she had responded and asked what happened but did not see the CNA's (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Golden Rule Home	38801 Hardesty Road Shawnee, OK 74801

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	subsequent reply. The ADON stated she found out about the alleged incident the next day but did not recall when she was told or how she found out. The ADON stated CNA #11 could have reported to the charge nurse that was working on the night of the alleged incident. The Director of Nursing (DON) was interviewed on 06/11/2026 at 3:20 PM and stated allegations of abuse had to be reported within two hours, and that had not been adequately completed, since the incident allegedly occurred on 05/18/2026 and was not reported to the SSA until 05/19/2026. A telephone interview was held with the SSD on 06/11/2026 at 4:11 PM. The SSD stated she was the facility's Abuse Coordinator and expected to be notified immediately for any allegations of abuse since there was a two-hour window to report allegations to the SSA. The SSD stated the two hours began as soon as someone in the facility was aware of the allegation. The SSD stated she was not notified of the alleged incident between CNA #10 and Resident #20 until sometime mid-morning on 05/19/2026. The DON was interviewed on 06/12/2026 at 1:10 PM. The DON stated she expected staff to report alleged or suspected abuse to the Abuse Coordinator, whose number was posted in the facility, or report to their supervisor. The Administrator was interviewed on 06/12/2026 at 3:07 PM and acknowledged the Abuse Coordinator was not made aware of the allegation involving Resident #20 and CNA #10 within the two-hour timeframe.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, medical record review, and facility policy review, the facility failed to ensure medication administration was accurately documented in the medical record for 1 (Resident #73) of 22 residents whose medical records were reviewed.Findings included: A facility policy titled, Charting Errors and/or Omissions, revised 12/2006, indicated, Accurate medical records shall be maintained by this facility. An admission Summary for Resident #73 revealed the facility admitted Resident #73 on 06/12/2023. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/12/2025, revealed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed Resident #73 had diagnoses that included dementia, anxiety, and respiratory failure. The MDS indicated Resident #73 had shortness of breath with exertion and when lying flat. Resident #73's Monthly Orders Sheets for February 2025 indicated Resident #73 had a physician's order dated 06/28/2023 for Ventolin hydrofluoroalkane (HFA) (an inhaled medication containing albuterol sulfate) two puffs by mouth every four hours as needed (PRN) for shortness of breath and wheezing. A Nurse's Notes entry dated 01/30/2025 at 4:30 PM indicated Resident #73 requested their PRN inhaler. The note indicated Resident #73 was given the inhaler then refused to give the inhaler back to the nurse. Resident #73's January 2025 medication administration record indicated Resident #73 received an as-needed (PRN) dose of the Ventolin HFA inhaler on 01/13/2025. There was no documentation the PRN inhaler was administered on any other date in January 2025. A Nurse's Notes entry dated 02/13/2025 for Resident #71 (Resident #73's roommate) indicated that Resident #73 requested an as-needed (PRN) breathing treatment, and Resident #71 became irritated and verbally aggressive when staff would not allow Resident #73 to have extra doses of med [medication]. Resident #73's February 2025 medication administration record did not indicate that Resident #73 had received the Ventolin HFA inhaler or any other inhaled medication during the month of February 2025. In an interview on 06/11/2026 at 10:15 AM, Advanced Certified Medication Aide (ACMA) #8 stated that when she administered a PRN inhaler, she would initial the MAR and document on the PRN medication sheet at the back of the MAR. ACMA #8 stated she would document before she administered the medication to ensure that she did not forget to document it. In an interview on 06/11/2026 at 10:18 AM, ACMA #7 stated he documented the administration of any PRN medication as soon as he was done giving it. ACMA #7 stated he had forgotten to document PRN medication administrations at times. ACMA #7 stated he remembered Resident #73 requesting their PRN inhaler frequently. In an interview on 06/11/2026 at 2:37 PM, Licensed Practical Nurse (LPN) #3 stated if a PRN medication or inhaler was administered, it should be documented in the MAR so staff could keep track of how often the resident was receiving the medication. In an interview on 06/12/2026 at 11:58 AM, the Director of Nursing (DON) stated Resident #73 would frequently talk about their inhaler. The DON stated Resident #73 would request the inhaler more frequently than it was ordered and would become upset if they could not get it. The DON stated that Resident #73 received the PRN inhaler frequently, and it should have been documented on the MAR. The DON stated she expected nursing to document medication administration appropriately. In an interview on 06/12/2026 at 12:50 PM, the Administrator (ADM) stated he expected staff to document any administration of PRN inhalers or medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure the proper storage of respiratory equipment for 1 (Resident #33) of 2 sampled residents reviewed for respiratory care, and failed to ensure staff used personal protective equipment (PPE) during the care of a resident on Enhanced Barrier Precautions (EBPs) for 1 (Resident #7) of 1 sampled resident reviewed for EBP. Specifically, Resident #33's nebulizer mouthpiece was not stored in a bag or closed container when not in use to prevent potential contamination, and staff performed wound and incontinence care for Resident #7 without donning the appropriate PPE.Findings included: 1. A facility policy titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised 10/2010, specified, The purpose of this procedure is to safely and aseptically administer aerosolized particles of medications into the resident's airway. The Steps in the Procedure indicated that after administering the treatment, staff should, 27. Rinse and disinfect the nebulizer equipment according to facility protocol, or: a. Wash pieces with warm, soapy water; b. Rinse with hot water; c. Place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. Soak for five minutes; d. Rinse all pieces with sterile water (NOT tap, bottled, or distilled); and e. Allow to air dry on a paper towel. 28. Wash and dry hands. 29. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. An undated facility document, titled, For Our Oxygen and Respiratory Customers, specified, Nebulizers. Keep circuit stored in a plastic bag labeled with pts [patient's] name and date. The document also indicated, Miscellaneous Disposable equipment should be covered when not in use. An admission Summary revealed the facility admitted Resident #33 on 11/14/2025. According to the admission Summary, the resident had a medical history that included diagnoses of essential hypertension and polyneuropathy. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) 02/17/2026, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had shortness of breath or trouble breathing with exertion. Resident #33's June 2026 Physician Orders contained an order, dated 11/14/2025, for ipratropium bromide 0.02 percent (%) inhale by mouth via nebulizer three times a day as needed. During a concurrent observation and interview on 06/08/2026 at 11:27 AM, Resident #33 was sitting in wheelchair in their room with a nebulizer machine on their bedside table. The medication chamber and mouthpiece were attached and lying directly on the bedside table with no cover/bag over the mouthpiece. Resident #3 stated they normally self-administered their nebulizer treatments. They stated the nebulizer mouthpiece was never stored in a bag but should be in a bag when not in use. During an observation on 06/08/2026 at 11:44 AM, Resident #33 was seated in a wheelchair in their room self-administering a nebulizer treatment. At 11:52 AM, Resident #33 remained seated in the wheelchair in their room. The nebulizer machine was on the bedside table with the mouthpiece lying directly on the bedside table, not covered or bagged. During an observation on 06/09/2026 at 1:23 PM, Resident #33 was seated in a wheelchair in their room. The nebulizer machine was on the bedside table with the mouthpiece resting directly on the bedside table, not covered or bagged. During an interview on 06/09/2026 at 1:28 PM, Licensed Practical Nurse (LPN) #2 confirmed that Resident #33 had a PRN [as needed] physician's order for ipratropium updraft treatments. She stated the nebulizer mouthpiece should be cleaned and dried after use and then stored in a bag until the next use. She stated the nebulizer mouthpiece should not be lying on the bedside table uncovered. During an interview on 06/09/2026 at 1:33 PM, LPN #3 stated he was responsible for Resident #33's care on 06/08/2026 and 06/09/2026. He confirmed that Resident #33 had a physician's order for ipratropium PRN. He stated that the process after administering a nebulizing treatment was to store the nebulizer's mouthpiece in a plastic bag. During a concurrent observation and interview on 06/09/2026 at 1:37 PM, LPN #3 confirmed that Resident #33's nebulizer mouthpiece was sitting on the bedside table with the mouthpiece touching the table and not bagged/contained. He then stated that all nurses were responsible for ensuring the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nebulizer's mouthpiece was bagged when not in use. He stated he made rounds hourly looking for proper respiratory equipment storage. He stated he expected the nebulizer's mouthpiece to be in a bag, even if it was a PRN physician's order, when not in use. During a concurrent observation and interview on 06/09/2026 at 1:45 PM, LPN #2 confirmed that Resident #33's nebulizer with mouthpiece was sitting on the bedside table with the mouthpiece touching the table. She stated that the nebulizer mouthpiece should be stored in a bag when not in use. During an interview on 06/09/2026 at 1:49 PM, LPN #2 stated she and LPN #3 were responsible for ensuring the nebulizer mouthpiece was stored properly in a bag when not in use. During an interview on 06/09/2026 at 2:26 PM, LPN #3 stated he put the nebulizer's mouthpiece in a bag and dated it. He stated he expected the nebulizer mouthpiece to be stored in a bag when not in use. During an interview on 06/10/2026 at 10:07 AM, the Nurse Practitioner (NP) stated it would be a smart idea to store the nebulizer mouthpiece in a bag when not in use. During an interview on 06/11/2026 at 9:05 AM, LPN #4 stated the nebulizer mouthpiece should always be stored in a bag when not in use and should not be sitting on a bedside table uncontained, as it was an infection control issue. During an interview on 06/11/2026 at 1:49 PM, the Pharmacist stated that a nebulizer's mouthpiece should be stored in a bag or container when not in use. During an interview on 06/11/2026 at 2:46 PM, the Director of Nursing (DON) stated that when a nebulizing mouthpiece was not being used, it should be stored in a bag to ensure proper infection control was maintained. During an interview on 06/11/2026 at 3:23 PM, the Administrator stated he would defer to nursing on how a nebulizing mouthpiece should be stored when not in use.2. The State Operations Manual (SOM) Appendix PP guidance at F880 indicated, Enhanced Barrier Precautions (EBP) are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [multi-drug-resistant organisms] to staff hands and clothing. EBP are indicated for residents with any of the following:- Infection or colonization with a CDC [Centers for Disease Control and Prevention]-targeted MDRO when Contact Precautions do not otherwise apply; or- Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. The guidance also specified, For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities:- Dressing- Bathing/showering- Transferring- Providing hygiene- Changing linens- Changing briefs or assisting with toileting- Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator- Wound care: any skin opening requiring a dressing. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/12/2026, revealed the facility re-admitted Resident #7 on 06/13/2025. The MDS indicated that Resident #7 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. The MDS also revealed that Resident #7 had one Stage 4 pressure ulcer that was present upon admission. Resident #7's Care Plan dated 06/16/2025 indicated the resident was being treated for two pressure wounds to the buttocks. On 06/11/2026 at 11:50 AM, an observation was made of the wound physician (WMD) and the wound Nurse Practitioner (WNP) measuring Resident #7's wound and providing a specialized treatment. Prior to the treatment beginning, it was noted that there was no Enhanced Barrier Precaution (EBP) sign on the resident's door. There was no personal protective equipment (PPE) beside the resident's door or inside the resident's room. Licensed Practical Nurse (LPN) #4 and Certified Nursing Assistant (CNA) #6 were observed transferring Resident #7 from the wheelchair to the bed, removing the resident's pants and brief, and preparing the resident for the measurements and treatment. LPN #4 and CNA #6 did not don gowns prior to the transfer. The WMD and the WNP wore gowns and gloves while measuring the resident's wound and providing the treatment. After the WMD and WNP completed the treatment, LPN #4 donned a disposable gown and completed wound care for Resident #7. After completion of the wound care, CNA #5 and CNA #6 provided incontinence care to Resident #7. CNA #6 and CNA #5 then applied a clean brief and transferred Resident #7 back to the wheelchair without donning gowns for protection. CNA #5 and CNA #6 were interviewed on 06/12/2026 at 10:32 AM. CNA #6 stated she had (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not been educated on EBP and was unaware of what the term meant. She stated she did not know she should have worn a gown when providing care to Resident #7. CNA #5 stated she did not know she should wear a gown when providing care to Resident #7. LPN #4 was unavailable for interview after the above observations. LPN #3 was interviewed on 06/12/2026 at 12:30 PM and stated he was not sure what EBP stood for and had not heard the term enhanced barrier precautions. Advanced Certified Medication Aide (ACMA) #7 was interviewed on 06/12/2026 at 12:54 PM. ACMA #7 stated he had heard the term enhanced barrier precautions and knew they were used when wound care was provided. The ACMA stated the type of PPE worn depended upon the type of wound a resident had. The Director of Nursing (DON) was interviewed on 06/12/2026 at 1:10 PM and stated she was familiar with the term EBP and that EBP should be in place for residents who had wounds, feeding tubes, indwelling urinary catheters, tracheostomies, and certain microorganisms. The DON stated signage should be on the door that notified all staff that the resident needed EBP. The DON admitted the facility had not been practicing EBP and stated she first realized this when she started her employment with the facility three weeks prior. The Administrator stated that he expected staff to follow infection control guidelines and the facility infection control policy.